Justice and Raiden Robinson

Fatality Review

Department of Social and Health Services
Children's Administration

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Acknowledgements and Preliminary Remarks

The DSHS Division of Children and Family Services (DCFS) wishes to thank all those who invested time and effort in this child fatality review process. Reviews of child deaths are very difficult. The only reward is if we can learn from such tragic outcomes. Indeed major practice changes in child welfare across the nation have come from lessons learned from child fatality reviews – both in terms of child abuse prevention and child abuse protection.

The panel included staff from Region 5 DCFS selected for their specialized knowledge and experience. This included individuals with expertise in Alternative Response System (ARS), Child Protective Services (CPS) intake, CPS investigation and risk assessment, supervision, workload, Indian Child Welfare (ICW), and Children's Administration (CA) policy.

Substantial effort was made to recruit members from the Kitsap County community who were recognized as experts in their given area of professional practice. Their selection was made to cover the fields of mental health, substance abuse, domestic violence, pediatrics, and Indian Child Welfare. The members from the community who participated were selected for their qualities as critical thinkers and not just for their expertise. A thank you is also given to those agencies that permitted their staff to participate.

In advance of meeting as a panel, each member was provided with a packet of documents regarding the Robinson family which they were asked to review. The panel met for two days at which time a great deal of information was reviewed, analyzed, discussed, and debated. The amount of time and energy that panel members gave to the review process is recognized and appreciated.

In addition to thanking the panel members, it is important to recognize DCFS staff who also contributed to the review. Social workers in both Bremerton and Seattle pulled together many documents used in the review. A thank you is also given to the DSHS and service provider staff who agreed to be interviewed during the review process.

Finally, appreciation is given to Mary Meinig (Director of the Office of Family and Children's Ombudsman) and Toni Sebastian (CA Practice Consultant, Office of Risk Management) who observed the review process. While largely observers, their comments and questions during the review added to the process.

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Introductory Comments - Framework of the Review Process

As directed by the Washington State Legislature, *"The Department of Social and Health Services shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death. Upon conclusion of the child fatality review required pursuant to subsection (1) of this section, the department shall issue a report on the results of the review to the appropriate committees of the legislature and shall make copies of the report available to the public upon request."* **RCW 74.13.640**

The DSHS Children's Administration (CA) is required to review all unanticipated child deaths that involve families who have received CA services in the previous year. The deaths may be from any unanticipated cause, not just those resulting from child abuse and neglect ("CA/N related") as was the case with the Robinson fatalities.

Children's Administration policy states that the purpose of a Child Fatality Review (CFR) is to examine all information provided to the department regarding the child and their family. The goals of child fatality review teams are to increase the understanding of the circumstances around a child's death and evaluate practice, programs and systems to improve the health and safety of children. These reviews must be completed within 180 days of CA receiving a report of the child's death. The roles of the review panel include the following:

1. To review the circumstances surrounding the fatality for possible CA/N issues.
2. To review whether policies and procedures in effect at the time of services to the family were followed for intake, service provision (CA and providers), risk assessment, CPS investigation, permanency planning services, supervisory review, and general documentation.
3. To note good practice.
4. To look at system issues.

To carry out the goals of fatality reviews it is the role of the panel members to review the information provided, and ask critical questions in the context of child welfare practice. The review identifies practice and/or system issues and concludes with recommendations. Recommendations are suggestions to DSHS, Children's Administration as to actions or consideration of actions that the panel believes will improve practice and reduce the likelihood of similar outcomes. These can be specific to a unit, office, region, or statewide.

Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.

EXECUTIVE SUMMARY

The Child Fatality Review team identified key areas of concern in the review of the Robinson case. As with any review of a case, a look back can reveal areas of practice and/or policies needing improvement.

Summary of Issues, Recommendations, and Actions Taken

CPS Intake

Several concerns were noted by the panel regarding some of the CPS intake reports involving the Robinson family. Many of the identified errors were minor, while some were more concerning. The failure to ask more questions and seek additional information at intake was noted for several of the referral intakes. The largest concern was the "downgrading" of referral #1349736 (September 17, 2003). That referral was directed to the Alternative Response System (ARS) provider, who had already engaged the family following an earlier referral for services. Based on the documentation reviewed, the panel concluded that "downgrading" referral #1349736 for ARS raised questions. The policy would support keeping a high risk tag given a situation such as this.

It was noted that CA continues to be committed to a statewide Intake Quality Assurance Model that addresses the issue of consistency of intake screening and risk tagging decisions. This effort seeks to identify areas of needed improvements that may be targeted for additional training or policy and practice changes. Numerous "peer reviews" and other types of intake sampling occur several times a year in each region and statewide.

Actions taken by Region 5 included the plan to address at the next regional Intake Unit Meeting the following: making reasonable collateral contacts at intake, information gathering, and the routing of "addendum to allegations" SERs to assigned field workers and their supervisors.

CPS Investigation

The assigned CPS worker met many policy and practice standards, though there were investigative tasks that were not adequately completed for the referrals in October 2003 and February 2004. There appear to be missed timelines for completing and documenting tasks. The panel felt that the investigative findings and assessments of the social worker were open to question, and had concerns regarding the frequency or adequacy of home visits and collateral contacts.

The case was left on "open/inactive" status (pending completion of paperwork) for a long period of time. While concerning, this does not appear to have significant implication for the fatality outcomes eight months later. Rather than the failure to complete required paperwork, it was the quality of the investigation and decision-making in the case that were the primary foci of the panel's discussions.

A number of recommendations and considerations were suggested by the fatality review panel regarding improvements in CPS delivery. These can be found in more detail in the body of this report. In summary, the recommendations included increased ongoing mandatory training e.g. substance abuse with a component on binge substance abuse; mental health cross-training; domestic violence training; annual "refresher" training for CPS workers on conducting high standard of investigation. An additional suggestion was for CA to monitor cases on "inactive" status statewide on an ongoing basis.

It was noted that CA had, prior to the Robinson fatalities, initiated several measures to improve child welfare services in the state of Washington. CA has been in process of developing a new model which separates investigation and on-going service provision/case management. CA has also requested funds to replace the CAMIS/GUI computer system which has been fraught with problems, and has proven difficult for users. In response to the Robinson child fatalities, CA ordered a statewide review of inactive cases.

Service Provision – Alternative Response System (ARS)

The panel noted concerns with the ARS delivery system. Several recommendations and considerations were suggested regarding the improvement of ARS services statewide and in Kitsap County. This included the recommendation that DCFS offer training to ARS providers on client engagement and how to help clients to access Indian Child Welfare services for Native American clients. It was suggested that CA re-examine the current benchmark measures for "successful outcome" of ARS services, and clarify the role and responsibilities expected of ARS workers under contract with DSHS.

Two actions were initiated by Region 5 with regard to improving cross-training between ARS and DCFS. The Bremerton Area Administrator will be added to the Bremerton-Kitsap County Health District training announcement list. The regional DCFS ARS Program Manager will begin to route training announcements to the regional ARS providers when such training is relevant and available to providers.

Service Provision – CPS

Few direct services were provided by CPS to the Robinson family. Following the CPS referrals in October 2003, a service agreement was developed, but more information regarding the client on an ongoing basis during the time the service agreement was in place would have assisted DSHS in case services. There appears to have been a lack of effective engagement of the family with the services outlined in the service agreement.

The panel recommendations to CA include providing social workers with training to support their understanding on how to best engage and hold substance using clients accountable to voluntary service agreements.

An additional recommendation relating to service provision is for CA to require domestic violence (DV) training for social workers and that such training should emphasize the importance of forging links with local DV resources. It was noted that CA is currently involved in ongoing discussions with community partners across the state as to how to respond to domestic violence. Several statewide and regional work groups are currently underway.

The panel noted that the social service system's lack of resources to adequately provide substance abuse and mental health services frequently impedes the ability of CA to serve families.

Assessment of Risk

The social worker's assessments of risk appeared to be inaccurate, but not to a substantial degree. There were noted concerns regarding the failure of the worker to seek information that may have improved the accuracy and confidence level of the assessments. Ms. Robinson's mental health issues remained unclear as to degree and kind. There were general indications of a history of depression, but whether

such condition was chronic, acute, pervasive, or situational (e.g., stress related or post-partum) remains unclear. With the exception of Ms. Robinson's brief hospitalization in 2002 for suicidal ideation and self-reporting "hearing voices," there is no indication of a history of similar extreme behaviors.

While clearly the Robinson children were at elevated risk, which is often the case with parents having even moderate substance abuse and mental health problems, there was no evidence that the children were clearly endangered at the time CPS was active or during the eight months following the CPS involvement. If the assumption is that the CPS worker "missed the signs" that children in the care of Ms. Robinson were at imminent risk of harm, then other professionals who had contact with the family also failed to recognize these signs.

The panel recommended that there be a revision of the Investigative Risk Assessment tool regarding the description of the "History of CA/N." Clarification as to the kind of information that should be summarized in this section is needed. Additionally, The Practice Guide to Risk Assessment (CA) should include guidance as to the duty of workers to summarize both referral and investigation history, as well as reported history of concerns from other sources that may not have been reported to Washington State CPS (e.g., reports of involvement with CPS in other states or reports from family members indicating unreported incidents of abuse and neglect). Furthermore, it was recommended that CA require ongoing training on risk assessment.

Workload

Workload appears to have contributed to many of the concerns identified in this report. Staff turnover, a predominantly inexperienced work force, and isolation of the ICW/CPS unit in the Bremerton DCFS office also contributed to the concerns found in the Robinson case.

The panel recommended that CA continue workload studies and seek remedies for unreasonable caseloads. The panel also called for a "response to workload crisis" policy that outlines specific actions and interventions that the department may take in response to emerging problems with increased referrals, vacancies/illnesses/extended leave within an office or region, etc.

A significant action taken by Bremerton DCFS regarding workload problems was the transfer of the ICW/CPS positions to the other CPS units in that office, which served to eliminate isolation of the ICW/CPS cases and to better accommodate the fluctuations in work flow.

Supervision

Concerns in supervision were identified and found to exacerbate the social worker's issues in meeting all practice standards. Workload issues appear to have contributed to the supervisory issues. While no specific recommendations were made with regard to needed changes in policy or practice regarding social work supervision, concerns are present regarding the lack of narrative text for monthly supervisory reviews during case staffings.

Conclusions

The referrals concerning Ms. Robinson and her children appear relatively routine in terms of the types of cases investigated by CPS and issues of child safety and risk. The episodic pattern of alcohol abuse by the parent was unusual, however, and made the case more complex in some respects.

There were avoidable errors in the child protection work and both the quantity and quality of service delivery were concerning. While the focus of the involvement by DCFS with Ms. Robinson was on the provision of voluntary services through an ARS provider and other community providers, efforts to engage the mother in such services and to monitor her participation in them fell short. However, a sufficient legal basis for involuntary intervention with the family by filing a dependency petition in juvenile court did not appear to be present at the time of either of the last two CPS referrals.

The panel concluded that, based on the information available to the CPS social worker at the time as well as the additional information obtained by the department and panel post-fatality, there did not appear to be grounds to petition the court in a dependency proceeding to place the children in out-of-home care or establish court monitoring of the family. If a parent does not follow through with voluntary services, the only available legal option for DCFS is to file a dependency petition.

While there were concerns in the CPS intervention with Ms. Robinson and her children, when considering the information that is now available and was available to the Department prior to the children's deaths, the fatalities were not reasonably predictable. The mother had numerous contacts with individuals, including mandated reporters and family members, and none raised concerns to CPS following the February 2004 CPS referral.

CASE OVERVIEW

Involvement of DCFS with Marie Robinson first occurred in 2001. Documents obtained post-fatality indicate the history of alcohol problems started years earlier and existed in her first marriage.

It is now known that Marie and Mark Robinson were married in 1989 in Texas. They had four children from their twelve year marriage, which ended in separation in 2001 and dissolution of marriage decreed January 18, 2002. Mr. Robinson indicated in court documents that his request for custody of the four children (then ages 11, 10, 6, and 1 year) was due to his wife's alcoholism and his inability to trust his wife to care for the children. Mr. Robinson's mother stated in her declaration to the court in 2001 that Ms. Robinson would often drink and stay drunk for days, and she believed Ms. Robinson needed help but would not get it until something drastic occurred. She stated that Ms. Robinson could have a lovely personality one minute, but when drinking, was mean in both words and attitude.

The first referral to CPS regarding Ms. Robinson was made on February 20, 2001. The previous month Ms. Robinson entered in-patient treatment and disclosed to a counselor that there had been loaded guns in her and her husband's bedroom, including recently underneath the bed. Information was that the guns had safety locks on them but were not in a gun safe. Ms. Robinson stated to her counselor that she had previously asked Mr. Robinson to remove the guns, but he refused. Ms. Robinson indicated the children were not allowed in the bedroom. The mandated reporter filed a report with CPS (February 20, 2001) which was taken as Information Only.

Sometime subsequent to this report, custody of the children was awarded to Mark Robinson. This information was obtained post-fatality.

In July of 2001, Ms. Robinson [redacted] reported being pregnant. In August 2001, Ms. Robinson was referred to Parent-Child Health (Kitsap County Health) by a licensed RN. [redacted]. Also in August 2001, a Family Planning and First Steps referral was sent to the Kitsap Health District [redacted]. This information was obtained by DCFS post-fatality in November 2004.

Around this time, Ms. Robinson began working for a private agency that provided respite care under a contract with the Division of Developmental Disabilities (DDD). Ms. Robinson's work was limited to a specific family with a disabled child. Information obtained post-fatality shows that Ms. Robinson was described by the family for whom she provided respite care as the "best" care provider the family had ever had.

Also, in 2001, Ms. Robinson and Christopher W. Bone met at an Alcoholics Anonymous gathering. While denying to the [redacted] that Mr. Bone was living with her, it appears that he was. In January 2002, she filed a domestic violence petition when she was eight months pregnant and resided for a time at a local women's shelter. She alleged that she had tried to get belongings from the home but Mr. Bone was drunk and in a rage. He allegedly choked and beat her and threatened the life of the unborn child. This information was received after the children's death.

In March 2002, Phoenix Robinson was born and Christopher Bone was listed as the father. In May 2002, Ms. Robinson accused Christopher Bone of raping her in front of their then nine-week-old son. A restraining order was issued and charges were filed against Mr. Bone. Mr. Bone was not convicted of these charges. At some point in time, Ms. Robinson became re-involved with Mr. Bone and she again became pregnant.

On September 10, 2002, CPS received a report from a concerned hospital social worker. Ms. Robinson had been admitted to the hospital allegedly due to a binge drinking episode. Soon after discharge Ms. Robinson returned to the hospital claiming she was hearing voices telling her to kill herself. The referral alleged that her five-month-old child was being cared for by a friend with a developmentally delayed daughter who might pose a risk to Phoenix's safety. The referral was assigned to the ARS and engagement was initiated with Ms. Robinson by the Kitsap County Health District.

While Ms. Robinson was in process of discharge from the hospital, another CPS report was received on September 17, 2002. A hospital social worker reported concern that Ms. Robinson was allegedly planning to resume care of her infant while still expressing trepidation regarding hurting herself. Ms. Robinson had also indicated that she had no food at her home (although connected to WIC). In reviewing the report, it appears that the intake supervisor determined that the mother had already initiated engagement with ARS and downgraded the second referral from high risk to low-moderate risk and forwarded the referral to ARS.

The ARS social worker connected with Ms. Robinson via a drop-in home visit. Ms. Robinson stated that she had a breakdown after having been raped recently [redacted]. She indicated that she had support from relatives and others. The ARS worker's documentation indicated that the apartment was clean and neat, that mother was well kempt as was the child and his room. The child was described as healthy, alert and happy. Ms. Robinson indicated a willingness to have the worker back to the home and was open to receiving services. In mid-December 2002, the ARS services were terminated with "all services completed."

In documents obtained after the children's deaths, it was learned that in late January 2003 the Bremerton [redacted] sent a First Steps referral to Kitsap Health District for Maternity Support Services, noting the mother's pregnancy. In February, a Pregnancy to Employment (PtE) assessment was completed for Ms. Robinson.

In late April 2003, Mr. Bone [redacted] with successful discharge in May. Two months later Justice Robinson was born with Mr. Bone listed as the father.

Medical records obtained post-fatality show that Justice was seen by a consulting physician for concerns relating to possible failure to thrive before four months of age. No CPS referral was made concerning this issue, nor did it appear one was indicated.[1] Possible causes were multiple, and zinc supplements were prescribed. Subsequent evaluation in late October 2003 showed weight gain had been made and the medical concerns appear to have diminished. By March 2004, Justice was no longer assessed as possible failure to thrive.

In September 2003, Ms. Robinson applied at the [redacted] assessment and a referral was made. There is no indication that Ms. Robinson followed through with [redacted].

The next contact with CPS was on October 8, 2003 when the paternal great-grandmother reported having been contacted by one of Ms. Robinson's neighbors who had observed Ms. Robinson drunk. The great-grandmother reported having gone to the home and found Ms. Robinson "staggering around the house" and Phoenix and Justice filthy (feces and urine soaked) as well as unfed ("starving"). Law enforcement was contacted and Ms. Robinson was taken to the hospital. The referral was initially taken as Information Only as the grandmother had assumed temporary care of the children, but was "upgraded" for assignment following an additional call to CPS intake by a mandated reporter who had concerns (although no direct knowledge) that Ms. Robinson might attempt to resume caretaking of her children.

The paternal great-grandmother again contacted CPS intake on October 13, 2003 requesting help with day care for the children. This second referral was taken as an Information Only report (request for services, no new allegations) and was similar in nature to information called in by a CSO worker, who had third-hand information regarding the situation (taken as an "addendum" to the original intake from October 8, 2003).

A CPS worker was assigned to investigate the matter on October 14, 2003. The paternal grandmother left a voice mail message for the supervisor the same day, but the supervisor was not able to contact that person and ended up having phone contact with the paternal great-grandmother instead. In that conversation the great-grandmother stated that Ms. Robinson was a "good mother" when not drinking.

The assigned social worker contacted the great-grandmother the following day and obtained additional information before conducting a home visit that same day. By this time the paternal great-grandmother had returned the children to Ms. Robinson. The mother and both children were seen during the home visit, and the situation assessed by the worker at that time was not found to be substantively concerning. The home was tidy and in order, food was available, and the care of the children appeared adequate. A signed written service agreement was obtained by the worker in which the parent agreed to follow through with her scheduled appointment with AGAPE (chemical dependency assessment/treatment services).

In November 2003, Ms. Robinson showed up [redacted] and an assessment was eventually completed. The results of the assessment (received by the department in mid-November) suggested [redacted]. In December 2003, the worker had contact with [redacted] and was informed that Ms. Robinson was not able to attend treatment until a medical matter had been cleared by a physician.

With the exception of two supervisory reviews that were documented, no other activities or contacts with the family were noted in the available records. The case was closed December 16, 2003. The allegations were determined to be "unfounded."

[1]RCW 26.44.030 requires mandated reporters to make a report to CPS or law enforcement whenever they have reasonable cause to believe that a child has suffered abuse or neglect.

On January 28, 2004, a relative contacted CPS intake with second hand information that there was no food in the Robinson home. The caller indicated that she had personally seen the children a week earlier, and they had looked good. There was definitive information that the paternal grandmother was in the home (recovering from an accident) and was helping to care for the children when Ms. Robinson did not, such as when she was in bed with a blanket over her head. The report was taken as Information Only (no allegations and no imminent harm assessed).

On February 7, 2004, the relative again contacted CPS intake to report that Ms. Robinson had been found in bed, apparently intoxicated and her two children were without adult supervision. The 22-month-old was found covered in ash from the unlit fireplace. Reportedly Ms. Robinson's use of alcohol had intensified. The report was accepted for investigation and assigned to the same social worker who had conducted the previous investigation.

Additional information was reported to CPS intake two days later, indicating that Ms. Robinson was again found in bed and there were four empty cases of beer in the closet. It was noted that there was another adult in the home (grandmother) who was able to care for the children. It was also reported that Ms. Robinson was currently taking medications. This information was taken as an "addendum" rather than a new report as there were no new allegations of CA/N and only additional information as to risk factors was provided.

The assigned social worker made some collateral contacts (grandmother, mother's identified tribe) but did not conduct face-to-face contact with the children or the mother until March 1, 2004 when a home visit occurred. At home were Ms. Robinson, Mr. Bone, and the two children. Ms. Robinson would neither confirm nor deny that she had recently relapsed. Mr. Bone reportedly indicated that he did not have any concerns regarding Ms. Robinson's care of the children, stating that she was "a good mother." Ms. Robinson refused to agree to a CPS written service agreement, and, unlike previous cooperative behavior, Ms. Robinson resisted any offer of help.

There were no further investigative or case management activities by the CPS worker, and the case appears to have gone inactive by mid-March 2004.

From information obtained after the children's deaths, it was learned that Ms. Robinson had by this time reported to her [redacted] that she was pregnant. Also in March 2004, Mr. Bone again entered [redacted]. The paternal great-grandmother had moved to Iowa, and the paternal grandmother had gone to Ohio to stay with relatives for a few months (returned in June 2004).

Information obtained post-fatality shows that in early May 2004, a [redacted] worker made a weekend visit to the Robinson residence wanting to check to see how Ms. Robinson and the children were doing on Mother's Day. That worker observed the home to be extremely clean, neat, and comfortable. The two children appeared cared for – clean, neat, and well fed. Ms. Robinson was observed to be attentive and appropriate with both children. Additionally, the [redacted] worker found Ms. Robinson to be well groomed, and appearing in good spirits despite being tired and uncomfortable due to the pregnancy. At that time, Ms. Robinson informed the [redacted] worker of plans to move to Kent. While [redacted] workers, like all DSHS workers, are mandated reporters, the worker's documentation of this home encounter show nothing she observed during the visit gave cause for concern.

By the end of May 2004, Ms. Robinson and her children appear to have moved to Kent, though this was not relayed to Bremerton CPS. Justice was seen at King County WIC on May 26, 2004. Documents obtained post-fatality show that at this time Justice's height/age was 25-50%, weight/age was 50-75%, and BMI/age was 75-85%. Justice Robinson was subsequently seen at WIC in July and September 2004.

[redacted] documents indicate that Ms. Robinson was to be involved with [redacted] King County from July-October 2004 but aborted treatment.

On August 27, 2004, Mr. Bone and his mother went to the Kent residence. The children were heard inside, but no one responded to knocking. Mr. Bone contacted law enforcement and a welfare check was done. The responding officers gained entry into the apartment and found Ms. Robinson in a back bedroom watching television. She indicated that she had not answered the door as she did not want to see Mr. Bone, indicating that there was a restraining order in place. Law enforcement observed that the mother was not drinking nor under the influence. The residence was found very clean and orderly, and the children looked cared for with no visible child abuse issues. The police arrested Mr. Bone on warrants and took him into custody. Law enforcement officers are also mandated reporters and no report was made to CPS regarding concern for the children.

In late September, Raiden Robinson was born in Renton. Birth records obtained post-fatality show 36-38 weeks gestation, Apgar scores of 9/9, length was 171/2 inches (0-5th percentile), weight was 5lbs 13 ounces (5th – 10th percentile), and weight-to-length was at the 0-5th percentile. The hospital made a referral to Public Health. CPS was not notified of Raiden's birth.

A home visit by a King County Public Health Nurse (PHN) occurred October 11, 2004. The identified problem was related to breastfeeding. Raiden was found to weigh 6 lbs. 5 oz. A second PHN visit occurred a week later. Marie Robinson declined to have Raiden weighed and reportedly was exclusively breastfeeding the infant. Public health nurses are mandated reporters, and they apparently did not see cause to make a referral to CPS.

On November 14, 2004, shortly before 3 p.m., the Kent Police responded to a welfare request from Mr. Bone, identifying himself as Ms. Robinson's boyfriend. Mr. Bone had been released from jail that morning and allegedly had been trying to contact Ms. Robinson by phone the past ten days. Mr. Bone had gone to the apartment, heard his two-year-old son Phoenix, but could not get anyone to open the door. He then contacted law enforcement who gained entry to residence where they found a naked and dirty child. The home smelled strongly of urine and feces. A search of the residence found 16-month-old Justice lying on his stomach deceased. In the master bedroom officers found the newborn, Raiden, in a bassinet covered with a blanket. The child was extremely emaciated and deceased. Ms. Robinson was found in the bed with covers over her head. The room was dark with a television on, the floor covered with dirty clothing, garbage, and empty beer cans. The strong odor along with the empty containers suggested the mother may have passed out due to intoxication. Ms. Robinson was taken into custody.

Cause of death for both Raiden and Justice Robinson was determined by the King County Medical Examiner to be from malnutrition and dehydration.

ISSUES AND RECOMMENDATIONS

Recommendations from the Robinson Fatality Review

The Child Fatality Review panel identified practice or system issues and made recommendations based on interviews with the assigned social worker, supervisor, ARS social worker and supervisor, and review of records from a variety of sources. Documents reviewed included an extensive chronology compiled by the Region 5 Division of Children and Family Services CPS Program Manager, the CPS case file records pre-fatality, documents obtained post-fatality, CA policy and practice standards, pertinent state laws, workload data, and information regarding worker and supervisor experience and training. No other

individuals were interviewed who may have had additional information related to the circumstances described in this review.

Many recommended actions/considerations do not relate directly to the fatality incident, but rather speak to general concerns that emerged during the review of the CPS service history and the context within which these fatalities occurred. The panel recognized the need to record significant comments, and these can be found in the report as well.

September 10, 2002 - Referral #1347451
Intake - ARS

A local hospital contacted CPS to report that while Ms. Robinson was being treated at the hospital she had left six-month-old Phoenix in the care of a friend whose living situation might pose a risk to Phoenix. The friend allegedly had a seven-year-old developmentally disabled child with violent tendencies who might possibly be jealous of the infant.

Information provided by the referent further indicated that Ms. Robinson had recently been admitted to the hospital following a seven day binge drinking episode after learning the father of her child was being released from jail. Mr. Bone (not identified by name in the referral) had been incarcerated on charges he had raped Ms. Robinson. Shortly after discharge from the hospital, Ms. Robinson returned claiming she was hearing voices telling her she should kill herself. Ms. Robinson was then admitted to the hospital psychiatric ward.

The main focus of the referral related to the immediate safety of Phoenix Robinson while in the care of a non-related adult when Ms. Robinson was hospitalized. Ms. Robinson had a relationship with the family as she had been the respite provider for that child through an agency that was contracted by DSHS Division of Developmental Disabilities (DDD). Contact with the child's DDD worker might have been considered, not only to obtain information relating to the possible threat the child might pose to Phoenix, but also as notification to DDD that Ms. Robinson, a respite provider, had been hospitalized for alcohol and mental health problems.

On the surface, the focus on concerns regarding the child care arrangements while Ms. Robinson was hospitalized seems reasonable. However, more critical consideration should have been made as to Ms. Robinson's capacity to provide safe care of Phoenix upon her hospital discharge and resumption of caretaking responsibilities [see also discussion of referral #1349736 below].

Additional information would have been beneficial, either by the intake worker asking more questions or through additional collateral contacts. There was little substantive information in the referral regarding the parent's mental health situation except that she had reported hearing voices when admitted to the hospital.

The intake supervisor's decision to change the report from "information only" to "accepted" appeared to be appropriate. "Information Only" referrals do not require a Child Abuse/Neglect (CA/N) code or identification of subjects and victim. When the report was upgraded to "accepted," a CA/N code and subject and victim should have been listed. Based on the information documented at intake, the decision to refer to ARS appears reasonable for this referral. It is not known if the intake worker had gathered additional information if this would have changed the screening decision.

Recommendations:

CA should continue to its commitment to a statewide Intake Quality Assurance Model which addresses the issue of consistency of practice related to screening risk tag and response decisions Discussion occurred regarding the possibility of directing certain low risk cases to an Early Intervention Program (EIP - Public Health Nurse) rather than ARS when children are under age one, so that general health and safety issues may be addressed. The EIP contracts are not currently set as an Alternative Response option.

September 17, 2002 - Referral #1349736
Intake - ARS

This referral generated several concerns as noted below. Subsequent to the earlier referral (see above) that had been routed to ARS for service engagement, another report was made to CPS on Ms. Robinson. Concern was reported by a hospital social worker as to Ms. Robinson resuming primary caretaking of her child upon hospital discharge. Ms. Robinson was reportedly still expressing concerns about hurting herself, and indicated to hospital staff that she had no food at her home although she was connected to WIC.

The intake supervisor changed the risk tag from high risk to low moderate (2) and routed the referral to ARS, which was already involved. Notation in the record indicates that the decision to downgrade the initial high risk/high standard of investigation referral to a low risk standard was based on ARS services being in place, and the client being receptive to services. The panel did not locate documentation indicating that the intake supervisor had directly contacted ARS to confirm services in progress. ARS records do show that by the date of the intake supervisor's "downgrade," ARS had made in-person contact with the client who had indicated a willingness to receive services.

Based on the documentation reviewed, the panel concluded that "downgrading" referral #1349736 for ARS raised questions. The policy would support keeping a high risk tag given a situation such as this. It was noted that the ARS social worker's assessment, derived from a field visit, did not indicate any significant or elevated concern for the welfare or safety of the child.

Policies exist regarding "downgrading" referrals. Current screening policy requires that any change to the screening decision (either downgrading or upgrading) must be made on the basis of new case information and be clearly documented, and the documentation must show the rationale for this change.

September 10, 2002 - Referral #1347451 and September 17, 2002 - Referral #1349736
ARS Intervention/Services

It is important to note that there are several models of ARS being used in the state. These include service provision through the Family Support Centers (e.g., Pierce County), Health Departments (primarily Public Health Nurse services), IFPS contracted (King County), and "Continuum of Care" (Kent). The Kitsap ARS services, provided through the Kitsap Health District, are provided by masters level social workers.

ARS initiated contact with the family in a timely manner for the first ARS referral (September 10, 2002). The ARS documentation shows a drop-in home visit was conducted following the first referral. Another home visit was scheduled but the ARS social worker was late to the appointment and missed the client. The ARS worker did not conduct a second home visit following the second referral, which was not consistent with the conditions of the ARS contract.

The ARS Services Summary indicated that all problems identified in the referral were resolved or partially resolved, but the documentation provided for this review did not describe what actual services were provided and how progress by the client was assessed. The services "termination code" in the services summary indicated "all services completed." The panel questioned the conclusion of the summary and the ARS supervisory oversight of this case.

During the fatality review, discussion occurred as to whether ARS workers could pursue collateral contacts to corroborate information provided by the parent(s). ARS providers are not obligated to make collateral contacts as should be done by CPS in high risk cases. However, in the ARS intervention for the Robinson case, the sole reliance on the parent's statements was found to be concerning.

While there was evidence that the mother's mental health issues were discussed during the home visit by the ARS social worker, the worker appears to have primarily relied on Ms. Robinson's statements that she had been merely "overwhelmed" and intended to seek counseling for depression and sexual assault victimization. There was mention of a referral to the Sexual Assault Center, but no indication that the ARS worker connected Ms. Robinson with that resource.

While there are indications that Ms. Robinson may have been familiar with DV resources in the community, the DV issue could have been given more attention by the ARS worker. While the ARS social worker had specialized training and experience in the area of DV, she reported that she did not make a referral for Ms. Robinson for DV services as she felt the mother had so many other things to do at that time.

It appears that Ms. Robinson's Native American cultural considerations were not followed up with at the time of these services. Ms. Robinson may have been eligible for services through local tribes/Bureau of Indian Affairs due to her claim of Native American ancestry [redacted].

The panel believes that statewide ICW training for ARS contracted providers that focuses on client access to services available through local tribes/BIA for those families claiming Native American ancestry should occur.

While ARS is a voluntary service and cannot compel a parent to participate in services, applying intervention and engagement strategies may improve the likelihood of a parent connecting with community services. One of the concepts in the creation of ARS was that, for lower risk situations, an effort to engage the family through a voluntary service plan would be more successful in reducing the risk of CA/N than an invasive and involuntary CPS investigation.

"Client Engagement Training" that is offered annually in Region 5 should be offered to ARS and other service providers contracted with the department in Region 5.

Consideration should be made for Region 5 DCFS to review the model that is currently used in Kitsap County (contract language), compare it with other ARS service expectations around the state, and assess whether improvements are needed in clarifying expectations of those contracted to provide ARS services. This would include the issue of making collateral contacts when deemed appropriate. Additionally, there appears to be a system confusion between how local community professionals view and measure "outcome success" and that of the department in terms of ARS data. Consideration should be given to looking at the local and statewide "outcome" measures for ARS intervention, and to review operational definitions of service delivery success.

Actions Taken:

The ARS Program Manager (Kitsap Health District) offered to put the Bremerton DCFS Area Administrator (or designee) on the Bremerton-Kitsap County Health District "training announcement" list. This would allow the opportunity for cross-training and multidisciplinary presentations relevant to Children and Family Services.

The Regional DCFS ARS Program Coordinator agreed to route training announcements to regional ARS providers when such training is open to contracted providers.

October 8, 2003 - Referral #1455899
Intake - Accepted CPS

The paternal great-grandmother contacted CPS to report that she had taken Phoenix and Justice Robinson from the care of their mother, Ms. Robinson. Having been alerted by a neighbor who had observed Ms. Robinson drunk, the great-grandmother went to the home and observed Ms. Robinson "staggering" and covered in bruises. The kids were allegedly found to be filthy, covered in urine and feces, and had not been fed ("were starving"). Reportedly, there was no food in the home. Following a call to 911 and a law enforcement response, Ms. Robinson was taken to a local hospital where she was found to have low potassium.

CPS intake was also contacted by two mandated reporters who were concerned about the possibility that Ms. Robinson would be attempting to regain caretaking of the children from the great-grandmother based on second-hand information. These additional concerns were documented as "addendum to allegations" rather than new reports as there were no new allegations. The review panel agreed with the intake decisions.

The decision by the intake supervisor to screen in referral #1455899 (October 8, 2003) under the high standard of investigation was deemed to be reasonable and appropriate. The referral was risk tagged as moderate (3) at intake. There was discussion in the panel as to whether the referral should have received a higher risk tag than it did. However, a higher risk tag would not have changed the investigative requirements for the CPS social worker. The response time designated at intake (non-emergent) was deemed reasonable given the information provided that indicated a relative had assumed caretaking of the children.

While there was sufficient information obtained at intake to make a screening decision, consideration might have been made to attempt to get information from the local hospital or from law enforcement which allegedly had responded to the home after the 911 call. It was noted during the review that no law enforcement report for this incident was found in the records obtained post-fatality from local law enforcement.

Recommendations:

CA is committed to continuing a statewide Intake Quality Assurance Model which addresses the issue of consistency of practice related to screening risk tag and response decisions.

October 8, 2003 - Referral #1455899
CPS Investigation

The referral was assigned to an ICW/CPS social worker on October 14, 2003. Both the worker and her supervisor contacted the referent, thereby initiating the investigation in a timely manner per policy. A home visit occurred October 15, 2003, and the initial face-to-face contact/interview of the alleged victims was conducted within the timeframe prescribed by policy. While the home visit was described by the worker as "unannounced" it is probable that Ms. Robinson anticipated contact by CPS. As the caretaker and alleged subject, Ms. Robinson was interviewed per policy. The social worker also sought to obtain information regarding tribal affiliation. The social worker input Service Episode Reports (SERs) in a timely manner consistent with policy expectations.

CA policy requires a "Safety Assessment" be conducted on all high standard CPS referrals assigned for investigation when a child is to remain in the home. As indicated in *The Practice Guide to Risk Assessment* (CA), a safety assessment is required immediately following the initial face-to-face contact with the child and, for referrals risk tagged as moderate, must be documented in the Case and Management Information System (CAMIS) or completed on the Safety Assessment - No Carbon Required (NCR) form within ten working days of the initial face-to-face with the child.

For this investigation, the Safety Assessment was created in CAMIS on December 11, 2003 two months after the reported date of the assessment (October 15, 2003). No NCR hard copy was found in the file, which would have indicated that a Safety Assessment was actually completed on October 15, 2003. The Safety Assessment was reviewed and approved by the supervisor at case closure. When interviewed by the review panel, the worker indicated that the Safety Assessment was late due to workload and a computer glitch in the CAMIS graphic user interface (GUI) program. The worker's untimely documentation of the Safety Assessment in CAMIS should have been noticed by the supervisor during the monthly case conference that is required by policy.

None of the eight Safety Assessment questions were marked "indicated" which means that the information available to the worker suggested the children were reasonably protected from serious and immediate harm, and a safety plan was not required in order for the children to remain in the home. "Serious and immediate harm" is defined by CA as meaning "the child is in danger of abuse and neglect that could result in death, life endangering illness, injury requiring medical attention, traumatic emotional harm or severe developmental harm that has lasting effects on the child's well-being" (*The Practice Guide to Risk Assessment*).

The review panel discussed the issue of caretaker impairment, which is one of the eight Safety Assessment questions to be evaluated. The fact that a parent had been alleged to be drunk and incapacitated at times would be given substantive consideration in the Safety Assessment process per departmental guidelines. The mere presence of a mental health issue or substance abuse problem does not mean, however, that a person cannot parent adequately or that the child is automatically unsafe (*The Practice Guide to Risk Assessment*). The worker stated that a combination of statements made by the great-grandmother (e.g., "Marie is a good mother when not drinking.") and observations during the home visit, led to the conclusion that, at the time of the field contact, Ms. Robinson did not evidence incapacity to parent to a "serious and immediate harm" level. The worker had worked as a drug and alcohol professional prior to working for the department, and thus had training and experience in the area of chemical dependency.

The fatality review panel concluded that the CPS worker's Safety Assessment may have been accurate given that there was no evidence that the children were, at that time of the field contact, at "serious and immediate harm" and thus no Safety Plan would have been required.

However, of significant concern to the review panel was the lack of information sought by the assigned social worker. While the CPS worker stated to the review panel that she believed she had made more contacts than were documented (e.g., family members), there were several other opportunities to obtain information relevant to the safety assessment process. The *CA Practice and Procedure Guide* states that workers need to "interview, in-person or by telephone, professionals and other persons (physician, nurse, school personnel, child day care, relatives, etc.) who are reported to have or, the social worker believes, may have first-hand knowledge of the incident, the injury, or the family's circumstances." If the worker had done this, it is unknown what additional first-hand information would have been received by the worker or whether it would have changed the outcome of the investigation.

The worker stated she had not attended the "High Standard of Investigation" refresher training that has been offered annually since 2002 to CPS workers in the Bremerton DCFS office. That training includes discussion on the importance of making collateral contacts and seeking additional information from a variety of sources.

Known referral history is printed out with every intake report. The original referral that went to the assigned CPS worker was found in the case file. It shows that the earlier referrals that had been sent to the ARS provider were listed in the "Referral History" section of the report. The worker indicated that she was unaware of the prior referrals, stating her belief that the referral copy she received had left off the history.

It appears that the worker did not have all of the information from prior ARS interventions. As part of the contract with DCFS, ARS providers must document their interventions in a report form, keeping on file their documents, and sending a Termination Summary to CA. In Region 5 the ARS providers also send to DCFS, a summary for each case, which is then input into CAMIS in the form of a brief SER under the referral number. The complete set of documents are not routinely sent to DCFS. Thus access to ARS documents must be requested by DCFS staff if they wish to review the ARS record. It was noted that there is nothing in policy requiring social workers to request prior ARS documents following a case being opened for investigation. It does not appear the social worker requested the ARS documents, although the ARS documents obtained post-fatality contained information that would have benefited the investigation.

The assigned CPS worker was aware that Ms. Robinson had lost custody of four other children to her ex-husband. There was very little documented about this issue, although the worker, when interviewed, indicated she was aware that alcohol problems were involved in the custody matter. The worker indicated that she never considered contacting the ex-husband since he was not involved with the situation and was not the father of the current children under his ex-wife's care.

Information gathered post-fatality relating to the divorce proceedings indicate allegations had been made by the ex-husband as to Ms. Robinson's history of drunkenness and inability to meet

the needs of their four children. The review panel believed that had this information been known, it would likely have made a significant difference in how the case was handled. The worker, when interviewed, agreed that such information may have resulted in a different case plan, but not necessarily affecting the decision to close the case in December 2003.

As a general practice, CPS workers do not routinely review divorce documents. They are often difficult to access from sealed family court records.

Previous referrals indicated that Ms. Robinson had been hospitalized for binge drinking and hearing voices and the service agreement signed by Ms. Robinson in response to this referral indicated that she would sign a release of information so the CPS worker could obtain information from outside sources. However, no signed release was found in the case file except for one obtained during a later investigation (March 2004), and it appears the SW did not obtain records from the mother's earlier hospitalizations. It is unknown what information would have been available, had she done this.

Also, the social worker did not seek any medical information on the children nor did she request a current medical assessment of the children. The worker indicated that she had not found the condition of the children to be concerning. Medical records obtained post-fatality show that Justice was seen by a consulting physician for concerns relating to possible failure-to-thrive before age four months. Possible causes were multiple, and zinc supplements were prescribed. No CPS referrals alleging CA/N related concerns were made by mandatory reporters involved with the family. Subsequent evaluation in late October 2003 showed weight gain had been made, and the medical concerns appear to have diminished. By March 2004, Justice was no longer assessed as possible failure-to-thrive.

The worker was aware that Ms. Robinson had been referred by her [redacted] for an intake at [redacted] (a state certified drug and alcohol program in [redacted] County). The worker did not contact the [redacted] whose records (obtained post-fatality) contained information regarding Ms. Robinson's alcohol abuse and depression issues and would have been beneficial for assessment and service planning.

Following the home visit, the worker did not contact [redacted] to confirm the evaluation appointment. The department did receive, on November 17, 2003, a report from [redacted], indicating that an evaluation had been conducted, and Ms. Robinson [redacted]. Ms. Robinson was given a list of treatment providers in Kitsap County, but did not immediately commit to treatment.

The worker made one home visit during the investigation of referral #1455899, and did not discuss the [redacted] with Ms. Robinson. The worker did have contact with [redacted] on December 10, 2003, at which time she was informed that Ms. Robinson would not be able to attend treatment until a medical situation was cleared by a physician. While it is true that the CPS worker did not contact the mother's physician to confirm a medical problem preventing continuation of treatment, there was some indication that the situation was confirmed by the [redacted] treatment provider.

The worker offered a written agreement (service plan) in a format frequently used by social workers in the Bremerton CPS office, and the client signed the agreement. The service agreement included conditions that Ms. Robinson would not use drugs or alcohol, would get an evaluation with [redacted], provide clean urine analysis (UA) or blood analysis (BA) with sampling being at the discretion of the treatment provider, follow through with all scheduled appointments, and provide a release of information for DCFS so that the CPS worker could obtain information from service providers.

In review, the panel noted what appears to be a lack of follow through or adequate monitoring of the service plan. The worker indicated that a heavy workload during that time required the prioritization of the case work, and on the surface the Robinson case appeared "less frightening" than other active CPS cases on her caseload.

The worker completed the Investigative Risk Assessment (IRA) within the 90 days prescribed by policy. The "History of CA/N" section of the CPS Investigative Assessment indicated "No prior hx with WA

CPS." This appears inaccurate due to the fact that there were prior CPS referrals (an Information Only referral and two ARS referrals).

The worker attended "Basic Risk Assessment Training" provided by the Region 5 CPS Coordinator. This training addresses summarizing both referrals and investigations, as well as reported history of concerns from other sources that may not have been reported to Washington State CPS (e.g., reports of involvement with CPS in other states or reports from family members indicating unreported incidents of abuse and neglect).

The "Baseline Level of Risk" assessed as low (1) by the social worker appeared to have underestimated the risks associated with the family history. It also appeared to the panel that the worker's "Description of most recent CA/N" was not complete. The worker did not make collateral contacts.

Many factors in the Risk Matrix appear accurate. These included child vulnerability/self protection, child special needs/behavioral problems, social support, economic resources, among other risk factors. Risk associated with substance abuse (assessed as moderate) did appear accurate given the guidelines found in *The Practice Guide to Risk Assessment*.

Some risk factors rated by the worker were concerning. For some factors, the under-assessment appeared to be due to a lack of conclusive information gathering. For example, the parent's mental/emotional impairment was assessed as zero risk, apparently based on how the parent presented. Domestic violence between partners was assessed as low moderate (2). Information obtained post-fatality, suggests a higher associated risk levels for both factors. The "recognition of problem/motivation to change" factor was also assessed as zero. This appears to be based on the client's verbal acknowledgment of problems.

Parenting skills were also assessed as zero risk. While this may have been an accurate reflection of Ms. Robinson when sober, it did not accurately reflect the situation when she drank. The risk matrix or the Overall Level of Risk narrative section of the Investigative Assessment was silent as to references to her "binge" drinking.

In the "Protective factors/Family strengths" section of the Risk Matrix, the worker appeared to rely heavily on the mother's stated understanding that she had a problem with alcohol with little comment on the mother's actions and behavioral change activities. While support of relatives was noted as a protective factor, the level of their involvement with the family (e.g., on-going involvement versus crisis intervention) was not clear.

The "Overall Level of Risk" assessed at closure was determined to be "low." As noted in *The Practice Guide to Risk Assessment* (CA), the overall level of risk is "a product of the interaction of risk factors rather than the presence or absence of any one or two factors." It is an assessment of a balance between risk factors that increase the probability of CA/N and protective factors that diminish the likelihood of CA/N.

In review of the social worker's assessed "Overall Level of Risk," the panel believed, with hindsight and additional information, that a higher risk level may have been more accurate. The lower level of risk assessed by the worker, at the time, was partly attributable to a lack of additional information and an over-reliance on the parent's point of view. The general consensus of the panel was that a more accurate "Overall Level of Risk" would have ranged from low moderate to moderate rather than low. Even at moderate risk, a community Child Protection Team staffing would not have been required.

During the panel interview, the social worker's supervisor indicated that accumulated cases had forced necessary prioritizing of investigative and case management activities in her unit, as well as affected the

ability to meet supervisory responsibilities. The supervisor did confirm the practice expectation for her unit CPS workers to do a minimum of two collateral contacts during investigations. The supervisor was present during the interview of the social worker and indicated awareness of the expectation for social workers to contact the [redacted] when CPS and [redacted] were both serving the same client.

The case was closed by the social worker on December 16, 2003, and supervisory sign-off occurred December 24, 2003.

Substantial time was spent by the review panel in discussing whether or not the case disposition (closure) was reasonable. The practice standard is for investigations to be concluded by the 90th day from the date of the referral. At that point the decision options are (1) to close the case, (2) to continue services under a voluntary service agreement with the child's caregivers, or (3) to seek legal intervention (dependency). As stated in the *CA Practice and Procedures Guide*, "the level of agency involvement with continuing service cases will be commensurate with the level of assessed risk."

Based on the workers overall assessed level of risk at closure, it is unlikely that legal intervention could have been supported. While the children were at some elevated risk, they were not assessed to be at imminent risk of harm at the time. The worker did not perceive a need to offer continued services past the ninety days. While some panel members struggled with this, the decision to close the case was found to be reasonable, although with a more manageable caseload, working with the family beyond the initial ninety days would have been optimal social work.

At the time of this investigation, the worker was one of two CPS workers in a specialized ICW unit. When the fatalities occurred in November 2004, the worker was the most veteran CPS Social Worker III in the Bremerton Office, yet had less than three years of CPS experience. Worker retention in the Bremerton DCFS office has been an identified problem over the last several years.

In June 2002, with the transfer of a co-worker in the ICW unit, the worker became the only CPS worker in the unit and remained so for six months until another worker began taking referrals for investigation. By that time, the worker had accumulated nearly twenty inactive cases. The worker had been unable to complete necessary documentation and closing paperwork. Unlike CPS workers in other units in the region, the worker had no opportunity for "cover-time" in order to close cases, and had a limited ability to ask for paid overtime.

Workload data was presented to the panel, which summarized caseloads for the social worker, her ICW/CPS unit, the non-ICW CPS units in the Bremerton office, and for the Tacoma CPS units. The claim by the social worker, her supervisor, and the Area Administrator for Bremerton ICW that the workload had become unmanageable is concerning.

Because of additional requirements in the Indian Child Welfare Act (involving tribes in case planning and providing active versus reasonable efforts as is required for non-Indian children at reunification), each ICW case is to be weighted in measuring workload with an additional three-tenths. Workload data provided to the panel members as part of the documentation packet showed that in October 2003 the assigned worker had been assigned 10 (weighted = 13) referrals requiring investigation, and the other ICW/CPS worker received a similar number of referrals. Additionally, the worker assigned to the Robinson investigation was carrying 43 cases (weighted = 56) by the end of October, with 23 needing to be closed and 20 active (weighted = 26). While the number of referral assignments went down in November and December 2003, the total number of cases (active and inactive) remained essentially the same.

In comparison, the average number of assignments for the non-ICW Bremerton CPS units for the same month was 6.3. Those units were also plagued with significant turnover and had inexperienced staff. The Tacoma CPS units averaged 8.4 assignments per month for the month of October 2003.

Both the number of referrals assigned and the worker's overall caseload were found to be inconsistent with the child welfare standards and Council on Accreditation (COA) standards. The COA standard for a CPS caseload is 15 (active for investigation at any given time). The Child Welfare League of America (CWLA) guidelines suggest a CPS caseload of 12 active investigations for any given 30-day period. Both the ICW Area Administrator and the Bremerton Area Administrator indicated that pervasive workload problems had been identified and discussed. The solutions to the problems, primarily involving "bumping" cases from the ICW/CPS unit to the Bremerton non-ICW CPS units, were initiated in the fall of 2003. However, this was not effective due to the significant turnover in the other CPS units and the backlog of cases that had developed in both the ICW/CPS and other CPS units.

In summary, the panel believed that many CA practice standard expectations for conducting CPS investigations may not have been met. The investigation reveals questions in meeting practice expectations for contacting collateral sources of information, obtaining records from community sources, following up and monitoring the service plan, and, to some degree, as to accurately assessing risk. However, workload may have indeed played a significant role in the deficits found.

Recommendations:

Revision of the Investigative Risk Assessment should be made as to the description of the "History of CA/N" section. Clarification as to the kind of information that should be summarized in this section is needed. Currently the "History of CA/N" section asks for a summary of prior history of CA/N victimization of children. *The Practice Guide to Risk Assessment* (CA) should include guidance as to the responsibility of workers to summarize both referral and investigation history, as well as reported history of concerns from other sources that may not have been reported to Washington State CPS (e.g., reports of involvement with CPS in other states or reports from family members indicating unreported incidents of abuse and neglect).

Reasonable workload expectations, both in terms of expected activities and number of cases (investigation and service provision) need to be re-visited by CA.

The CA Case and Management Information System (CAMIS) and its Graphic User Interface (GUI) are fraught with problems and difficult to use. The effort to implement a different computer data base system should continue as currently planned by CA.

Effort should be made to produce a "Response to Workload Crisis" policy that outlines specific actions and interventions supported by regional administration. While there appears to have been an effort made in Region 5, it was not initiated until after the problem had become severe. Any workload crisis plan should include guidelines for dealing with emergency response to vacancies, when workers cannot be assigned cases (e.g., have not completed the six week academy), when workers are out ill or on other extended leave, etc.

Basic risk assessment training should be mandatory to CPS units in all offices. This training includes expectations regarding the conducting of high standard investigations, risk assessment, service planning, and making findings. Additionally, "refresher" training on both "Findings" and on "High Standard of Investigation" has also been offered annually in Region 5 for several years. Every year CPS social

workers should be required to attend High Standard of Investigation training either as part of the Academy, the regional one day "Basic Risk Assessment" training, the two hour refresher course, or the statewide "High Standard of Investigation" training that is currently being developed by CA. The latter training will be based on the new "Screening and Investigation" best practice guide for social workers that is expected to be completed and disseminated to staff by July 2005.

Substance abuse and addiction are widespread problems in the families served by CA. Accurately assessing substance abuse issues and associated risks is critical to all DCFS social workers working with families. However, the fact that substance abuse treatment services are often not readily available in certain communities needs to be recognized. There are often waiting lists for treatment and "short-term inpatient treatment services" cannot address the multiple and compounding problems of many clients involved with CPS. State budget limits have been a barrier to providing clients with immediate access to long-term treatment.

Assessing risk associated with mental health issues is challenging, and is especially so when the client has both mental health and addiction issues. Social workers do not generally have expertise in the area of mental health. Training opportunities are frequently available to social workers regarding substance abuse, however, fewer are available regarding the risk parents' mental health disorders pose to their children. Consideration should be made to do more cross-training with mental health professionals in Kitsap County.

It appears that the social worker did not seek information regarding Ms. Robinson's mental health issues. It is questionable as to whether there would have been readily available and effective services in the community. Mental health services in Kitsap County, like so many other communities around the state, are limited to the most severely affected, and clients are most frequently served by group therapy. Ms. Robinson may have benefited from individual mental health counseling more than group counseling, but it is unclear that she would have qualified for such service. Similar to substance abuse, state budget limits have been a barrier to providing clients with immediate access to mental health treatment. The panel concluded that the failure of the social service system to adequately support mental health treatment frequently impedes the ability of CA to serve families.

CA should continue its work with community partners in developing protocols for intervening with families in which domestic violence is an issue.

Actions Taken:

The Bremerton ICW/CPS positions have been transferred to Bremerton non-ICW CPS units, giving that office more flexibility to handle fluctuations in work flow.

October 13, 2003 - Referral #1457215
Intake - Information Only

Several days after having assumed care of the children, the great-grandmother called CPS intake requesting day care. The decision to designate referral #1457215 as "Information Only" was deemed appropriate. The information provided was additional, but not new. The great-grandmother was identified as the "primary caretaker" for the referral. While she may have been temporarily providing

care for the two Robinson children, the mother should have been identified as the primary caretaker per intake practice standards. The referral text indicates that the report was a Child Welfare Service (CWS) request. While the great-grandmother was requesting services (day care), it was more appropriately a request for services on an open CPS case. It appears the screening decision on this referral did not affect the outcome of this case.

Recommendations:

Policies and practice standards regarding identification of "primary caretaker" exist and appear to be adequate.

January 28, 2004 - Referral # 1485190
Intake - Information Only

A relative contacted CPS intake to report that the paternal grandmother of the children had stated to family members that there was no food in the Robinson home. The grandmother was staying at the home while recovering from injuries sustained in a car accident. The referent indicated she had also been to the home and while the children "looked good," Ms. Robinson had been observed in bed with a blanket over her head. There was a concern that Ms. Robinson might be drinking again.

The decision at intake to screen out this referral (i.e., to take as "Information Only") appears to be questionable. The information provided appeared to credibly suggest that the children's basic needs (food and supervision) were not being met. This was considered sufficient to meet the criteria for initiating a CPS investigation.

The referrer's statements regarding having recently seen the children and "they looked good" and that the grandmother was providing some care of the children was reviewed by the panel. Gathering positive information about a family at intake is an intake practice expectation as indicated by the statewide CPS Intake Review Tool (Question #11: *Were family strengths and protective factors for the child/ren asked or identified in the referral?*). This raised the issue of equating children who appear to "look okay/look good" as sufficient evidence of no neglect or minimal risk of neglect.

A bias that may have played a role in the intake decision was that of assuming that a relative living in the home improved safety. In this case, the paternal grandmother of the children staying at the residence was recovering from injuries to the degree that she allegedly needed help caring for herself. This raised the issue as to how active and reliable the grandmother could be as a care provider for the children. Additional questions at intake would have been beneficial in determining associated risk.

The intake worker did not appear to contact the prior social worker who had closed the case a month earlier. The *CA Practices and Procedures Guide* does not indicate a requirement that intake workers contact prior social workers. It does state that collateral contacts should be made if there is insufficient information from the referrer to determine if the referral should be accepted for investigation or if collateral sources might have information which would be useful in arriving at the intake risk tag. Intake workers should review the prior Investigative Risk Assessments to obtain information that is helpful in their decision-making. This is usually documented in the "History of Child Abuse and Neglect" risk section in a referral. No such documentation was found. The apparent failure by the intake social worker to contact the prior social worker or document having reviewed the prior Investigative Risk Assessment was of concern to the panel.

The review panel concluded that the referral should have screened in, minimally, as a low standard referral or possibly as a high standard of investigation referral. This was based on the allegations (although relatively minor in terms of severity), the identified risk factors (including past history, similar issues in the past, and current concerns that Ms. Robinson might be drinking again), and questionable sufficient protective factors.

Recommendations:

Children's Administration is committed to continuing a statewide Intake Quality Assurance Model which addresses the issue of consistency of practice related to screening risk tag and response decisions.

Actions Taken:

The issue of reasonable collateral contacts at intake, including contacting prior social workers, is on the agenda for the next Region 5 Intake Unit Meeting. This will be a review of practice expectations and documentation.

February 7, 2004 - Referral #1488486
Intake - Accepted

The relative who contacted CPS in late January 2004 again contacted intake. She reported that the children's paternal grandmother had found Ms. Robinson asleep in bed and 22-month-old Phoenix playing in the unlit fireplace, with ashes all over. Ms. Robinson allegedly was intoxicated at the time, and her use of alcohol appeared to have intensified in the last couple of weeks.

Additional information was called into intake by the referent on February 9, 2004, after the referral had been assigned to the social worker. The referent indicated that she had found Ms. Robinson in bed and was unable to get her up. Four empty cases of beer were in the closet and Ms. Robinson was reportedly taking medications. The referent indicated that there was another adult in the home who was able to care for the children. The information was deemed to be additional rather than a new allegation, and thus was taken as "addendum to allegations" and documented in an SER (consistent with intake procedures). This decision was found to be reasonable.

When interviewed by the panel, the assigned social worker indicated she was not aware of the information contained in the "addendum to allegations" narrative completed by an intake worker as it was not included on the original intake report. This was confirmed in review of the available case file documents. It was noted during the review that the intake practice in Region 5 is for any "addendums to allegations" to be routed to the assigning CPS supervisor for accepted referrals. In this case, it appears that the "addendum" was never routed. The fact that the assigned worker never received the additional information was concerning to the panel as well as to the worker and supervisor.

It appeared to the panel that none of the intake issues identified for this referral had any direct relation to the fatality situation ten months later. However, the panel believed information taken by intake as an "addendum to allegations" that the worker did not receive would likely have raised concern regarding the safety of the children and future risk and may have affected the investigation of the February 2004 referral.

Recommendations:

The panel recommended no change to current CA policies or procedures.

Actions Taken:

The practice of making sure "addendum to allegation" narratives (which are taken after a referral has already been sent to a field supervisor for assignment) get routed appropriately will be on the agenda at an up-coming Region 5 Intake Unit Meeting.

February 7, 2004 - Referral #1488486
Investigation

The assigned social worker initiated the investigation within ten calendar days as evidenced by documented contact with the paternal grandmother and an effort to contact representatives from the mother's tribe ([redacted] located in California). Additionally, the worker attempted to seek information from Kitsap Jail booking as to Mr. Bone. The documentation of these activities was within the timeframe specified by policy for initiation of a CPS investigation.

The worker did not conduct a face-to-face contact/interviews with alleged victims within ten days. It was nearly one month from the date of the referral before the worker conducted a home visit and made contact with the alleged victims and subject (March 1, 2004). No supervisory waiver of the initial face-to-face timeframe was found in the case file. The first documented supervisory review/consult was conducted two weeks after the home visit had occurred.

The worker completed a Safety Assessment within two days of initial face-to-face contact with the alleged victims, which is the requirement for referrals risk tagged as moderate-high or high. The Safety Assessment was done on NCR form, as allowed by policy. Policy also requires documentation in CAMIS within ten working days of the initial face-to-face. This did not occur. The worker's failure to meet the specified timeframe for entering the Safety Assessment into CAMIS should have been noticed by the supervisor during the monthly case conference that is required by policy.

None of the eight Safety Assessment questions were marked "indicated," which means that the information available to the worker suggested the children were reasonably protected from serious and immediate harm and a safety plan was not required in order for the children to remain in the home.[2] The fatality review panel concluded that the CPS worker's Safety Assessment was likely reasonable given that there was no evidence that the children were, at that time of the field contact, at "serious and immediate harm" and thus no Safety Plan would have been required.

During the home visit, the father of the children was present. He indicated that he had no concerns about Ms. Robinson's care of the children, stating that she was a "good mother." During the interview (but not in the worker's documentation), the worker stated that the presence of Mr. Bone appeared to have affected how Ms. Robinson responded to CPS contact. Previously Ms. Robinson had been very cooperative and responsive, but this time she was not. It appeared to the review panel that the change in the mother's demeanor was attributable to the presence of the father. The worker did not do a statewide criminal background check on either parent, and such a check of Mr. Bone would have shown a criminal history. While there is no requirement by CPS to routinely conduct criminal background inquiries, such activity would have certainly added to the knowledge base from which to make assessment of risk and

[2]"Serious and immediate harm" is defined by CA as meaning "the child is in danger of abuse and neglect that could result in death, life endgangering illness, injury requiring medical attention, traumatic emotional harm or severe developmental harm that has lasting effects on the child's well-being" *(The Practice Guide to Risk Assessment).*

for case decisions, especially cases where there is alleged DV history. The panel believed the worker should have arranged for another meeting without the presence of Mr. Bone.

Ms. Robinson would neither confirm nor deny the alleged relapse. While the mother signed a release of information authorizing CPS to contact the treatment provider [redacted], she appeared less committed to any ongoing services and refused to sign a voluntary service agreement. The worker documented having discussed with both parents the risks Ms. Robinson's drinking posed to the children.

The panel believed that the mother's apparent change in attitude regarding her alcohol dependence should have been a "red flag" and pursued more aggressively by the social worker while the case was active. The worker's SER notation indicates she told Ms. Robinson to contact [redacted] to let them know that CPS was again involved.

The lack of collateral contacts, including the aforementioned failure to contact the substance abuse treatment provider was noted. The panel believed that a reasonable action would have been for the worker to make the contact with [redacted] to verify that the client had followed through.

The worker did not contact the [redacted] to obtain information regarding Ms. Robinson or Mr. Bone. The [redacted] documents obtained post-fatality show that on March 8, 2004, the [redacted] was aware that Ms. Robinson was reportedly pregnant. When interviewed by the panel, the worker indicated she had no knowledge that the mother was pregnant with another child by Mr. Bone. Collaboration with the CSO would have been an opportunity to obtain information and to do collaborative service planning. The supervisor was present during the interview of the social worker, and did indicate awareness of the expectation for workers to contact the [redacted] when CPS and [redacted] were both serving the same client. The supervisor indicated she routinely encourages her social work staff to collaborate with the [redacted].

As noted previously, known referral history is printed out with every intake report. The original referral that went to the assigned CPS worker was found in the case file and it clearly shows the earlier ARS referrals. While there is nothing in policy requiring social workers to request prior ARS documents following a case being opened for investigation, best practice would suggest such action.

Also as noted previously, the supervisor did confirm the practice expectation for her unit CPS workers to do a minimum of two collateral contacts. This did not occur during this investigation. The focus on the quantity of collaterals rather than the quality (type, relevance, importance, sufficiency) was found to be concerning. It was clear to the review panel that there were several missed opportunities to obtain relevant information from critical sources.

Other than the one home visit conducted on March 1, 2004, there was no further contact with the family. The *CA Practices and Procedures Guide* states that "unless credible collateral contacts clearly indicate that neglect is not occurring," the investigating worker is to "make a home visit in cases of child neglect and in other cases when a home visit is necessary to complete a risk assessment of the family." While the worker did meet the minimal practice standard for home visits, the panel believed that more than the one home visit should have occurred in this case, given the nature of the concerns and the history.

Shortly after the home visit by the social worker, all social work activity stopped, and the case apparently went to "inactive" status. The *CA Operations Manual* makes a distinction between open cases (active and inactive) and closed cases. The purpose of identifying a case as "Services Inactive/Paperwork Pending" is to allow for and to track cases which are in process of completion of

documentation. The *CA Operations Manual* states that the social worker "must complete all forms and narrative recordings within 90 days of a decision to terminate services and close a case." This did not occur.

Other policies are in apparent conflict with this 90 day policy. SERs are required to be input into CAMIS within 30 days of the activity being documented (near verbatim interviews are to be input into CAMIS within15 days of the activity). By policy "the social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation and no later than the 90th day after the referral is received" (*CA Practices and Procedures Guide*).

For the Robinson investigation, the case status remained "open" but was not "active" as CPS was no longer investigating or providing services to the family and/or child. The worker maintained that by the end of March 2004 the case was pending closure with the plan to complete case documentation. The Investigative Risk Assessment was not completed by the worker until eight months later (November 15, 2004) following the report of the child fatalities.

A supervisory review was conducted per policy in March 2004 as evidenced by documentation in SER. No text was found in the SER entry made by the supervisor, and none are required by policy.

A second supervisory review was done in May 2004, and narrative text added post-fatality (November 2004) indicates that the supervisor discussed with the social worker preparation for case closure at that time. A third supervisory review SER was entered in June 2004 (no text) and no further entries were made until after the November fatalities. The supervisor indicated during her interview that her monthly case conferences do not address, by necessity, all cases. The supervisor clarified by indicating that it would be impossible, given the high number of "open/inactive" cases, to review every case – that there would not be enough time to accommodate such an expectation.

The fact that the case remained "inactive" for such a long period of time was concerning to the review panel – both in terms of the social work practice and the supervision. Had the documentation been completed as required, it would have been available for review by CA at the time of the fatalities. The lack of documentation and misinformation caused unnecessary problems following the fatalities. The fact that the worker did not complete an investigative risk assessment until after the fatalities is problematic. As with the prior risk assessment, the panel believed the overall level of risk was underestimated. But again, the assessed level of risk (low moderate) was not found to be excessively underestimated. The panel concluded that a realistic overall level of risk would have been moderate or moderately high.

In completing the documentation after the death of the children, the worker determined the allegations from February 7, 2004 were "unfounded." The panel discussed whether or not such a finding was supportable. The panel believed that due to the issues raised about the investigation and documentation, a determination on this matter would be speculative. However, had the worker made a finding of "founded" for neglect in March of 2004, it would not likely have led to any legal intervention.

Workload data was presented to the panel which summarized caseloads for the social worker, her ICW/CPS unit, the non-ICW CPS units in the Bremerton office, and for the Tacoma CPS units during the period of time the worker was investigating this referral. The claims by the social worker, her supervisor, and the Area Administrator for Bremerton ICW that the staff was continuing to experience the cumulative effects of the workload problem appear to be supported.

As noted previously, each ICW case is to be weighted an additional 30 percent due to the additional requirements of working with tribes and providing "active" efforts as required under the Indian Child Welfare Act. Workload data provided to the panel members showed that by February and March 2004 the worker was receiving between seven and nine (weighted) referrals a month, which were similar to average referral assignments for other CPS workers in the Bremerton and Tacoma offices. Additionally, the worker assigned to the Robinson investigation was still carrying over 35 cases (unweighted) of which only 15-17 were active.

In summary, the panel believed that many CA practice standard expectations for conducting CPS investigations were not met for this referral. Workload played a significant role in the deficits found.

Recommendations:

Most of the recommendations and considerations emerging from the review of the second investigation were similar to those identified for the first investigation. They can be summarized as follows.

- The need to revise the directions provided to workers for completing the "History of CA/N" section of the CPS Investigative Assessment to clarify what information should be summarized in that section of the assessment.
- A "response to workload crisis" or some other "emergency plan" protocol needs to be developed, either regionally or statewide, to respond to surges in workload created by vacancies or increased referrals.
- Effort by CA to study workload should be continued.
- Workers should be required to attend post-academy training on high standard of investigation, and Region 5 should consider requiring all CPS workers to annually take a two-hour refresher course.
- CA should consider requiring all social workers to attend substance abuse training periodically and these trainings should include guidance as to engaging substance abusing clients in treatment and holding clients accountable. Additionally, while binge drinking problems are not frequently identified in CPS investigations, consideration should be given that any training offered by the department on substance abuse includes a segment on binge substance abuse.
- Consideration should also be made to do more cross-training with mental health providers in Kitsap County.

The panel also reiterated its opinion that the failure of the social service system to satisfactorily support substance abuse treatment and mental health treatment often impedes the ability of CA to serve families.

A recommendation specific to the second investigation focused on the issue of "inactive status." Action was taken by CA following the Robinson fatalities, and this was noted during the review. CA ordered a statewide review of open CPS cases to identify "inactive" cases and to initiate review and closure of these cases. It is clear that the worker and supervisor did not conform to policy or practice standards that are in effect. Consideration should be made by Region 5 Administration to review and reiterate policy and practice expectations governing inactive case status at an upcoming Regional All Supervisor and Program Manager Staff Meeting.